Money Follows the Person Program Appendix to all LTC Medicaid Waiver Manuals

Last Updated: 04/20/2022

Table of Contents

Purpose of the Money Follows the Person Demonstration Program 3
MFP Eligibility 4
MFP Enrollment 7
Transition Planning (MFP) 9
Service Authorizations (MFP) 12
Transition Coordination (MFP) 12
Transition Services (MFP) 15
Environmental Modifications (MFP) 21
Assistive Technology (MFP) 24

Money Follows the Person Program Appendix to all LTC Medicaid Waiver Manuals

The Money Follows the Person (MFP) Demonstration Program is a federal initiative to assist certain individuals to move from an institution to a home-and-community-based setting made possible by the Deficit Reduction Act of 2005 and initiated in Virginia in 2008. MFP is a federal opportunity to further develop community integration strategies, systems, and infrastructure for people with long-term support needs.

The term “individual” means “participant” in this Appendix.

Purpose of the Money Follows the Person Demonstration Program

The purpose of the MFP Demonstration Program is to give individuals who live in institutional settings enhanced options to transition into the community. To fulfill this purpose, Virginia’s MFP Demonstration Program has three goals:

Goal 1: Rebalancing Virginia’s long-term support system, giving individuals more informed choices and options about where they live and receive services;

Goal 2: Assisting individuals to transition from institutions, such as: Intermediate Care Facilities for Individuals with Intellectual Disabilities

(ICF/IID), nursing facilities (NFs), long-stay hospitals (LSHs), Institutions for Mental Diseases (IMDs), and Psychiatric Residential Treatment Facilities (PRTFs) who want to live in the community; and

Goal 3: Promoting quality care through long-term supports that are person-centered and appropriate, addressing strengths, needs, preferences, health status, and risk factors while ensuring continual improvements are made through a quality management strategy for home and community-based services (HCBS) settings and institutions.

MFP Transition Coordinators (TCs) and Case Managers (CMs) will ensure that individuals are aware of their rights and available services to assist in meeting needs in any setting. NFs, ICFs/IID, LSHs, IMDs and PRTFs will provide information to

individuals who want to transition to their homes and communities. The facilities will serve as a point of contact, for the discharge planning process, and will work together with the Transition Coordinator (TC) or Case Manager (CM) to provide a smooth transition for the individual.

MFP Eligibility

To be eligible for MFP, an individual must:

- Be a resident of the Commonwealth of Virginia; and,
- Have received Medicaid benefits for inpatient services for at least one day immediately prior to MFP participation (individuals between the ages of 22 and 64 may not transition directly from an IMD since Medicaid benefits for inpatient services are not provided in an IMD); and,
- Reside for at least 90 consecutive inpatient days in a qualified institution. Residency in NFs, LSHs, ICFs-IID, IMDs, and PRTFs, or a combination thereof; counts toward the 90 consecutive day requirement. Any days spent in an institution for the purposes of receiving short-term skilled rehabilitation services reimbursed under Medicare do not count toward the 90 days; and,
- Qualify for one of the following home and community-based long-term care support program, or waivers :
    - Elderly or Disabled with Consumer Direction Waiver (EDCD);
    - Individual and Family Developmental Disabilities Support Waiver (IFDDS);
    - Intellectual Disability (ID) Waiver;
    - Technology Assisted Waiver (Tech); or,
    - The Program of All-Inclusive Care for the Elderly (PACE); and,
- Choose to relocate to a “qualified residence.” A qualified residence is: (1) a home that is owned or leased by the individual or the individual’s family member(s); (2) an apartment with an individual lease, with lockable entry and exit, which includes living, sleeping, bathing and cooking areas over which the

individual or the individual's family has domain and control; or, (3) a residence in a community-based residential setting in which no more than four unrelated individuals reside.

1. A home owned or leased by the individual or the individual's family member; the lease/deed must be held by the individual or the individual's family member.

    - If leased, the lease must be the MFP participant or a family representative.

    - If an MFP participant would like to share the home they own or lease with other private individuals, including other MFP participant(s), they may either:

        - Sublet or rent their home with a lease granting the other individual(s) exclusive possession to the space being leased or sublet; or
        - Enter into a co-ownership or co-leasing arrangement with the other private individual(s).

In either of these circumstances, all parties must retain independent and equal legal rights to enforcement of the lease and/or ownership responsibilities and, if the other parties are MFP participants, those individuals retain responsibility for meeting the qualified residence requirements.

2. An apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control.

    - The dwelling must have a lease that is considered a legal document by all parties signing or referenced in the lease. The lease may be signed by someone other than the individual or the individual's family

representative.

- The lease must not name anyone other than the MFP participant or a family representative as having domain and control over living, sleeping, bathing, and cooking areas of the dwelling.

- The building must give access to the community. For example, in order to assure security, safety or privacy many apartment complexes have gates, multiple doors, or security guard checkpoints leading to an exit on the street outside of the complex. Each tenant or their family representative must be provided a key, identification card, or keypunch number to easily get in or out of a complex or facility 24 hours a day.

- The apartment in which the MFP participant resides must have lockable entrance or egress to the unit not just the building.

- The apartment in which the MFP participant resides must comply with federal fair housing guidelines.

To be a qualified residence under MFP, leases should not:

- Include rules and/or regulations from a service agency *as conditions of tenancy* or include a requirement to receive services from a specific company;

- Require notification of periods of absence, e.g. a person who is absent from a facility for more than 15 consecutive days, or discuss transfer to a nursing facility or hospital;

- Include provisions for being admitted, discharged, or transferred out of or into a facility; or

- Reserve the right to assign apartments and change apartment assignments.

3. A residence, in a community-based residential setting, in which no more than four unrelated individuals reside.

- This residence may be owned and operated by a person or organization other than the individual.

- A residence in which no more than four unrelated individuals reside and that is part of a larger congregate care setting (campus) separated from typical community dwellings would not be considered a qualified residence.

- Caregivers, such as personal attendants, are not counted in the four maximum unrelated individuals.

(*Source: DHHS/Centers for Medicare & Medicaid Services, MFP Policy Guidance Housing, February 25, 2008)*

Individuals who have a less than 90 days stay in an institution may transition to a community setting but will not be eligible for the MFP Program.

Individuals who are interested in transitioning should discuss the MFP program with the staff where they reside. The staff should assist the individuals in obtaining the necessary information to make an informed choice regarding participation in the MFP Program. Individuals must be offered choice regarding all aspects of the program from selection of providers to their desired community setting.

MFP Enrollment

The enrollment process is as follows:

The TC or CM will:

- Obtain a Uniform Assessment Instrument (UAI) (guidance regarding the UAI is found in Chapter 4 of the Pre-Admission Screening Provider Manual) or Level of Functioning (LOF) Survey (Guidance for LOF is found in Chapter 4 of the ID Community Services and IFDDS Waiver Services Provider Manuals) ;
- Complete the MFP Informed Consent form (DMAS 221)
- Complete the MFP Enrollment form (DMAS 222), and
- Administer the initial Quality of Life Survey (DMAS 416) once community housing has been obtained but prior to discharge.

Submission:

- Fax copies of the DMAS 221, DMAS 222 and DMAS 416 to DMAS at 804-452-5468 for all individuals.

In addition,

- ID Waiver: ID Waiver CMs will fax the DMAS 222 to the Department of Behavioral Health and Developmental Services (DBHDS) (804-786-8626).
- DBHDS will respond by assigning a MFP slot to the Community Services Board in the Intellectual Disability On- Line System (IDOLS).
- IFDDS Waiver: IFDDS Waiver CMs will notify their DBHDS DD contact person that the individual is interested in MFP and fax the DMAS 221, DMAS 222 and DMAS 416 to DMAS at 804-452-5468. The DBHDS DD Contact Person will coordinate with the MFP program Staff for enrollment and authorization.
- EDCD Waiver: Effective September 1, 2015, TCs must submit MFP requests, service type 0909, for service authorization to KEPRO electronically using Atrezzo Connect (also known as Atrezzo).
- Tech Waiver: Long stay hospital staff will notify their DMAS Tech Waiver contact person that the individual is interested in transitioning using MFP. The Tech Waiver contact person will work with the MFP Program Staff to obtain enrollment

and service authorization.
- PACE: Transition Coordinators will contact MFP Program Staff to obtain enrollment and service authorization.

TCs, and CMs must follow the established process for waiver enrollment.

Transition Planning (MFP)

It is the responsibility of the discharging facility to work with the individual and their T C or CM to secure necessary services prior to and upon discharge.

Responsibilities for transition planning include but are not limited to:

- Complete a Risk Assessment and Mitigation Plan. This written person-centered document includes: identifying risks for transition to the community, outlines how these risks will be addressed and is periodically reviewed and modified so that it is responsive to evolving risk over time. Risks and plans to address those risks include health and medical risks, behavioral and mental health risks, stability of the informal caregiver network, issues of social isolation and financial risk. The Risk Assessment and Mitigation Plan should be reviewed frequently (at least monthly after transition) and revised as needed.

- Develop a person-centered transition and service plan (TCs use the DMAS 220 to help inform the development of a transition and service plan, and CMs develop an individual support plan or use the DMAS 456/457 depending on Waiver utilization);
- The person-centered transition service plan should be written. Documentation of consumer choice regarding services and providers should be maintained. The plan should clearly identify what services the individual will need in order to live in the community, when and how the person will transition, and include amount, time and type of supports and transition services needed by the individual such as:

- housing,
- security deposits,
- transportation,
- supplies and/or furnishings, or
- clothing and/or identification card.

- Develop and document a written four-tiered backup plan. Documentation must include explaining the following four-tiered backup plan to the MFP Participant.

Tier 1: Individual Person-Centered Service Plan Providers

For each essential service identified in the person-centered service plan, there must be a **provider that agrees to respond 24/7 as needed.** The backup providers listed in the first tier of the person-centered service will include the existing providers of services (whether it is an agency or consumer-directed employee). If living in a group home, assisted living facility, or other living arrangement that is licensed, certified or regulated by the Commonwealth of Virginia, the provider is required to manage services in the event of an emergency or a break-down in services.

Tier 2: Informal Network

In the event that the backup providers listed in the first tier are not able to fill in as planned, the second tier in the back may be **family, friends, or neighbors** who may be able to provide interim supports.

Tier 3: 24-hour Response System

If the backup planned in the first two tiers do not solve the problem, the Tier 3 backup option is available. Individuals may dial 2-1-1toll free. When an individual dials 2-1-1, a 2-1-1 Call Specialist will answer the phone. This specialist will assist in finding needed essential services and resources when planned backups in the first two tiers are not available and/or do not solve the problem.

When speaking with a 2-1-1 Call Specialist, the individual should identify themselves as an individual participating in the "Money Follows the Person Program." The 2-1-1 Call Specialists follow specific protocols for MFP participants. In addition, the call will be followed and tracked.

Tier 4: Extreme Emergency Backup

In the event of an immediate crisis involving a threat to health, safety, or life, MFP participants should know how to call 911.

(Sources: Virginia MFP Operational Protocol and DHHS/Centers for Medicare & Medicaid Services, MFP Policy Guidance, Clarification of Quality Requirements, April 3, 2013)

- The coordination of community-based services such as transportation, employment and/or volunteer options, and social supports.
- Linkage to services needed prior to transition and enrollment into a Community – Based Care program, such as peer counseling, budget management training, transportation; and housing.
- Coordination of discharge date with the facility to ensure that facility charges and waiver enrollment do not conflict.
- Coordination of notifications for changes in any type of SSI, SSDI or other payments.
- Submission of change of address to the Department of Social Services.
- The provision of ongoing transition coordination support for up to 12 months (EDCD Waiver) after discharge date.
- Assuring modification of transition and service plans as needed.
- Development and maintenance of documentation to verify transition services and transition coordination were rendered as billed.
- Verification that all invoiced transition services have been received.
- Documentation of the individual's transition progress noting services and supports provided to the individual.
- Submission to DMAS MFP staff of any change of contact information for the individual (allowing DMAS MFP staff to administer first and second year

Quality of Life Surveys).
- Summation notes regarding individual's community integration progress at the close of the first year of transition.

Individuals may not receive Transition Coordination, and Case Management services at the same time. Only one provider may provide and bill for this service for the activities listed above.

Service Authorizations (MFP)

MFP Enrollment/Participation requires service authorization (as listed above). The process for service authorization for transition coordination and transition services is described below. For information regarding the DMAS Service Authorization Process, please refer to the service authorization appendix in the individual Home and Community-Based Care Provider Policy Manual for the specific waiver or program in which the individual will be enrolled.

Transition Coordination (MFP)

Under the EDCD Waiver and use in conjunction with PACE

(Procedure Code H2015)

Service Definition

Transition Coordination is provided by the DMAS-enrolled provider who is responsible for supporting the individual and individual's representative, as appropriate, with the activities associated with transitioning from an institution to the community. For the EDCD Waiver, service authorization is for a total of 14 months, 2 months prior to facility discharge and 12 months post discharge. For individuals entering PACE, Transition Coordination authorization is for a total of three months, 2 months prior to facility discharge and 1 month post discharge.

Criteria

In order to qualify for a Transition Coordinator documented need shall indicate that the transition service plan cannot be implemented effectively and efficiently without Transition Coordination. Use of a Transition Coordinator must be authorized by DMAS or its designated agent. A service authorization must be submitted and approved for this service both for the 2 month pre-discharge period (Service

Authorization Type 0909) and then again for the 12 months post-discharge period under the EDCD waiver (Service Authorization Type 0900).

Service Units and Service Limitations

The unit of service is one (1) with a frequency of monthly. The services shall be explicitly detailed in the supporting documentation. Travel time is not billable under transition coordination. Transition coordination may not be billed solely for purposes of monitoring. Transition coordination shall be available only to individuals who are transitioning from institutional care to the community. Transition coordination providers shall be reimbursed according to the amount and type of service authorized in the transition service plan.

The reimbursement rate may be found on the DMAS website under the Provider Information Section. The website link is: http://www.dmas.virginia.gov/Content_pgs/ltc-wvr.aspx.

Provider Qualifications

In addition to meeting the general conditions and requirements for home and community- based care, participating Transition Coordination providers, as specified in 12VAC30- 120-930 and12VAC30-120-2000, shall meet the following qualifications:

1. Transition Coordinators shall be employed by one of the following: a local government agency; a private, nonprofit organization qualified under 26 USC §501(c)(3); or a fiscal management service with experience in providing this service.

2. A qualified Transition Coordinator shall be at least 21 years of age and possess, at a minimum, a bachelor's degree in human services or health care and relevant experience that indicates the provider possesses the following knowledge, skills, and abilities. These shall be documented on the Transition Coordinator's job application form or supporting documentation, or observable in the job or

promotion interview and documented in interview notes.

- Knowledge: Transition Coordinators shall have knowledge of aging, independent living, the impact of disabilities on individuals; individual assessments (including psychosocial, health, and functional factors) and their uses in person-centered service planning, interviewing techniques, individuals' rights, local human and health service delivery systems, including support services and public benefits eligibility requirements, principles of human behavior and interpersonal relationships, interpersonal communication principles and techniques, general principles of file documentation, the person-centered service planning process, and the major components of a service plan.

- Skills: Transition Coordinators shall have skills in negotiating with individuals and service providers; observing, and reporting behaviors; identifying and documenting an individual's needs for resources, services and other assistance; identifying services within the established services system to meet the individual's needs; coordinating the provision of services by diverse public and private providers; analyzing and planning for the service needs of the individual; and assessing individuals using DMAS' authorized assessment forms.

- Abilities: Transition Coordinators shall have the ability to demonstrate a positive regard for individuals, their families and designated guardian; remain objective; work as a team member, maintain effective interagency and intra-agency working relationships; work independently, performing position duties under general supervision; communicate effectively, both verbally and in writing; develop rapport; communicate with different types of persons from diverse cultural backgrounds; and conduct interviews.

3. The provider must comply with § 32.1-162.9:1 of the *Code of Virginia* regarding criminal record checks and sex offender and crimes against minors obtained through the Virginia State Police. Documentation of a criminal background check must be maintained in the personnel file for review by DMAS staff.

Provider Documentation Requirements

1. Supporting documentation of the need for the service.
2. A DMAS 220
3. A person-centered transition service plan which includes, at a minimum:
    a. a summary of or reference to the Transition Coordinator assessment;
    b. the individual's strengths, needs, preferences, health status, risk factors, goals and measurable objectives for addressing each identified need;
    c. the services, supports, and frequency of service to achieve the desired outcomes and action steps;
    d. clear identification of which services are essential, and require a back- up plan;
    e. the existence of a back-up plan for the essential services;
    f. target dates for accomplishment of the desired outcomes and action steps;
    g. estimated duration of service;
    h. the role of other agencies if the plan is a shared responsibility; and
    i. staff responsible for coordination and integration of services, including the staff of other agencies if the plan is a shared responsibility.
4. Documentation of the date services are rendered and the amount of services.

Providers are required to maintain documentation and records according to Federal and State record retention policies.

Transition Services (MFP)

(Procedure Code T2038)

Transition services are available for MFP participants for two months pre-transition/discharge. This service is also available under the following waivers: EDCD, IFDDS, ID, TECH, and one month post discharge for the Program for All- Inclusive Care for the Elderly (PACE).

Service Definition

Transition Services are a means of providing for set-up expenses for individuals who are transitioning from an institution or licensed or certified provider-operated living arrangement to a living arrangement in a private residence where the person is directly responsible for his or her own living expenses.

Individuals may receive Transition Services for up to 9 months through the MFP Program, EDCD, Tech, IFDDS, ID waivers and for the first month in PACE. Individuals who leave a qualified institution prior to enrolling in MFP, but demonstrate a need for Transition Services have 30 days to apply for the service post transition.

Transition Services shall be service authorized for nine (9) months by DMAS or its designated agent prior to providing services. The DMAS designated fiscal agent shall manage the reimbursement for the transition services. The TC or CM, as appropriate to the waiver, shall ensure that the request for reimbursement is reasonable and does not exceed the $5,000 maximum limit

All individuals using EDCD, ID, IFDDS, or TECH waivers or PACE must have these services included on a person-centered transition service plan prior to seeking servicer authorization from DBHDS or the DMAS designated agent.

Allowable costs include, but are not limited to:

- Security deposits that are required to obtain a lease on an house, condo, apartment or other residence; Essential household furnishings and appliances required to occupy and use a community domicile, for example furniture, window coverings, food preparation items, and bed/bath linens;
- Connection or set-up fees or deposits for utility or services access, such as telephone, electricity, heating and water;
- Services necessary for the individual’s health, safety, and welfare such as pest eradication and one-time cleaning prior to occupancy;
- Moving expenses;
- Needed clothing items; and

- Fees to obtain a copy of a birth certificate, identification card, or driver's license.

Non-allowable costs include, but are not limited to:

- Reoccurring charges such as monthly rental or mortgage expenses;
- Food;
- Regular utility charges;
- Household items that are intended for decoration, diversional or recreational purposes; and
- Services or items that are covered under other waiver services such as chore, homemaker, environmental modifications and adaptations, or specialized supplies and equipment.

Criteria

Transition services are furnished only to the extent that:

- they are reasonable and necessary as determined through the transition service plan development process,
- they are clearly identified in the transition service plan,
- the person is unable to meet such expense, and
- the goods/services cannot be obtained from another source.

This service does not include services or items that are covered under other waiver services, or state plan options, or by other providers.

Service Units and Service Limitations

Services are available for one transition per individual and must be expended within nine months from the date of authorization. The funds shall not be available to the individual after that period of time. The total cost of these services shall not exceed $5,000, per person lifetime limit coverage of transition costs to residents of NFs, LSHs, ICFs/IID, PRTFs or IMDs who are Medicaid recipients and are able to return to the community. The DMAS designated fiscal agent shall manage the accounting of the transition service. The TC or CM shall ensure that the funding spent is reasonable and necessary and does not exceed the $5,000 maximum limit.

Transition Services may be requested up to two months prior to discharge or within 30 days after a transition. If not requested within that time frame, the individual will not be considered for transition services.

Provider Qualifications

Providers must be enrolled as a Medicaid Provider for Transition Coordination or Case Management and work with the DMAS designated agent to receive reimbursement for the purchase of appropriate transition goods or services on behalf of the individual.

PUBLIC PARTNERSHIPS, LLC - FISCAL AGENT

DMAS has a contract with Public Partnerships, LLC (PPL) for managing the reimbursement to Transition Services Provider agencies for transition services PPL is responsible for tracking and reimbursing, as appropriate, local agencies' expenditures to vendors for goods and services purchased to assist with transition of the individual to their community homes.

Tracking and Reconciling Expenditures

Once authorized for Transition Services, TCs and CMs may utilize up to $5,000 per person, per lifetime, for the purchase of essential goods and/or services. Funding must be spent within nine months from the date of authorization. PPL supports a secure website that provides TCs and CMs access to individual expenditure and balance information for Transition Services.

This interactive website is designed to enable on-line submission of requests, tracking of individual monetary balances, receive scanned receipts and generate invoices. The agency for which the TC or CM works will be responsible for providing the "up-front" funds for pre-approved purchase(s) and then requesting reimbursement from PPL.

PPL reviews and approved/denies or pends items/services requested and purchased, and provides direct reimbursement of approved expenditures to community-based agencies.

All agencies must complete a provider enrollment packet with PPL. Please contact PPL at 1-866-529-7550 or

http://www.publicpartnerships.com/programs/virginia/index.html

or pplva1@pcgus.com to obtain provider forms and password information.

The Transition Services Provider agency will be assigned a pass code for access to the web portal. Each representative will have the ability to access only records of individuals for whom they coordinate Transition Services. All providers are required to submit estimates for requested items and services, justify expenditure requests within the description section for goods and services on PPL's web portal, provide receipts for purchases and generate expenditure invoices/claims for services. PPL reimburses vendors for approved procured goods and services based upon information provided within the web portal. Requests that are identified as failing to meet the expenditure requirements will be either pended or denied. Transition Services Provider agencies are responsible for procuring only those items that are identified as necessary and reasonable, not supplied by another source, and that comply with purchase guidance and requirements. PPL will track expenses via the website to ensure expenses for the individual does not exceed the $5,000 lifetime maximum.

PPL provides a toll-free customer service hotline operating Monday-Friday from 8 a.m. to 8 p.m. for individuals, family members, TCs, and CMs. The toll free number is 1-866- 529-7550.

Submission of Claims and Payment Process

The TC, or CM, enters estimates for Transition Services into the PPL web portal.

These estimates are pending until authorized or denied according to residential setting, and category. A receipt must be obtained and electronically submitted or

faxed, along with the invoice/claim through the PPL web portal. PPL will reimburse the provider agency (via Electronic Funds Transfer directly to the agency). Specific information regarding entry, invoicing and allowable services can be found on the PPL website at https://www.publicpartnerships.com/

Service Units and Service Limitations

Any requests received by the fiscal agent for transition services which exceed $2,000 by category will be routed to DMAS for review and approval. The review and approval by DMAS will need to take place prior to expending any funds for Transition Services.

The TC or CM shall work closely with the individual to assure that all costs are reasonable and necessary for transitioning from the institution to the home-and-community-based setting.

Documentation Requirements:

- Documentation of need for the requested goods and/or services on the person- centered transition service plan, including the discussion of need with the individual or his representative, as appropriate;
- Documentation of the individual's or his representative's, as appropriate, choice of services or goods to be purchased ;
- Documentation of the individual's or his representative's, as appropriate, choice of vendor, if applicable;
- Documentation of the reasonableness of the expense (consideration should be given to ways to provide the items or service in the least expensive, most cost effective manner);
- Documentation of the date services are rendered and the amount of services and supplies;
- Any other relevant information regarding the purchase;
- Documentation of satisfaction regarding completion of the service and receipt of the purchase by the individual and/ or individual's representative, as appropriate;
- As appropriate, documentation that the MFP Participant has received instructions regarding any warranty, repairs, complaints, and servicing that may be needed; and
- Retention in the record of a receipt for the purchased services and/or goods

which documents payment of the fee.

Transition Services purchases must match the items that are listed on the transition service plan.

Environmental Modifications (MFP)

(Procedure Codes: For new modifications use code S5165, for Maintenance of a previous modification use code 99199U4) Environmental Modifications are available in the IFDDS, ID and Tech Waivers. Please check Chapter IV of those Waiver Manuals for information regarding Environmental Modifications.

For the EDCD waiver, Environmental Modifications are available only if an individual is also enrolled in the MFP Program for the requested dates of service. Information is provided below regarding this service in the EDCD Waiver.

Service Definition

Environmental modifications (EM) are physical adaptations to a house, place of residence, primary vehicle and or work site (when the work site modifications exceed reasonable accommodation requirements of the Americans with Disabilities Act) that are necessary to ensure the health and safety, or enable individual's functioning with greater independence. The adaptation may not be used to bring a substandard dwelling up to minimum habilitation standards. All services shall be provided in accordance with applicable state or local building codes.

This service does not include those adaptations or improvements to the home, which are of general utility and are not direct medical or remedial benefit to the individual (i.e., carpeting, roof repair, central air conditioning, etc.). Adaptations, which add to the total square footage of the home, are not allowable expenditures, except when they are necessary to complete the modification (for example, in order to improve entry to or exit from a residence or to configure a bathroom to accommodate a

wheelchair. Modifications are also not allowable if some other law (for example the Fair Housing Act or the Virginia Fair Housing Law) requires the modification to be completed by a third party.

Activities

The modifications and activities may include:

Installation of specialized electric and plumbing systems to accommodate medical equipment and supplies, grab bars, widening of doorways, installation of ramps, modifications of bathroom facilities.

Criteria

This service is available to individuals who are receiving at least one other qualifying waiver service.

The provider and individual may work with five people to complete modifications:

1. A Rehabilitation Engineer or Rehabilitation Specialist may be used to evaluate the individual's needs and acts as project manager, assuring functionality of the EM through quality assurance inspections upon the completion of the project. The Rehabilitation Engineer may also design and personally complete the modification.
2. A Physical Therapist, Speech Therapist or Occupational Therapist, available through the *State Plan for Medical Assistance*, may also be utilized to evaluate the needs for EM. (NOTE: Under the *State Plan for Medical Assistance*, Physical, Occupational, and Speech Therapy services must be preauthorized through the DMAS Service Authorized Contractor if more than five visits have been provided to the individual. Visits are individual-specific, not provider-specific.).
3. A building contractor may design and complete structural modifications.

4. A vendor who supplies the necessary materials may be separately reimbursed or supplies may be included in the bill of the building contractor or Rehabilitation Engineer.
5. A durable medical equipment (DME) provider enrolled with DMAS may bill for modifications.

A Rehabilitation Engineer might be required if (for example):

- The EM involves combinations of systems which, by original design, do not go together; or
- The structural modification requires a project manager to assure that design and functionality meet ADA accessibility guidelines or that the residence is structurally sound for the modifications.

Service Units and Service Limitations.

The maximum Medicaid-funded expenditure for EM or maintenance in the EDCD waiver is $5,000. The Service Authorization must be made during the MFP participation year. Each modification must be service authorized by DMAS and or the DMAS designated contractor.

EM will be covered in the least expensive, most cost effective manner. Any request for a change in cost (increase or decrease) requires justification, supporting documentation of medical need and a revision to the Service Authorization approved by DMAS and/or the DMAS designated contractor.

Provider Documentation Requirements:

The requirements are:

- Supporting documentation must include the need for the service, the process to obtain the service (contacts with potential contractors of service, costs, etc.), and the time frame during which the service is to be provided. This includes a separate notation of the evaluation, design, labor, and supplies or materials, or both. The supporting documentation must include documentation of the reason that a Rehabilitation Engineer is needed, if one

is to be involved;
- Documentation of the date services are rendered and the amount of services and supplies;

- Any other relevant information regarding the modification;
- Documentation that the TC or CM, upon completion of each modification, met face-to-face with the individual and the family/caregiver, as appropriate, to ensure that the modification was completed satisfactorily and is able to be used by the individual;
- Instructions regarding any warranty, repairs, complaints, and servicing that may be needed;
- More than one cost estimate may be required; and
- Receipts are required for any purchased goods or services.

Assistive Technology (MFP)

(T1999)

Assistive Technology is available in the IFDDS, ID and Tech Waivers. Please check Chapter IV of those Waiver Manuals for information regarding Assistive Technology.

For the EDCD Waiver, Assistive Technology is available only if an individual is also enrolled in the MFP Program for the requested dates of service. Information is provided below regarding this service in the EDCD Waiver.

Service Definition

Assistive Technology (AT) is specialized medical equipment and supplies, devices, controls, and appliances, not available under the *State Plan for Medical Assistance*, which enable individuals to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live, or which are necessary to their proper functioning. AT devices must be portable.

Activities

The equipment and activities not available under the State Plan for Medical Assistance are:

1. Specialized medical equipment, ancillary equipment, and supplies necessary for life support;
2. Durable or non-durable medical equipment and supplies (DME);
3. Adaptive devices, appliances, and controls which enable an individual to be more independent in areas of activities of daily living (which includes personal care) and instrumental activities of daily living; and
4. Equipment and devices which enable an individual to communicate more effectively.

Criteria

This service is available to individuals who are receiving at least one other qualifying waiver service. Items will not be approved for purposes of convenience of the caregiver or restraint of the individual using the waiver. AT shall be covered in the least expensive, most cost-effective manner.

Equipment or supplies already covered by the *State Plan for Medical Assistance* may not be purchased under the waiver as assistive technology. A copy of the DME and Supplies list is available from DMAS and should be used to ascertain whether an item is covered through the *State Plan for Medical Assistance* before requesting it through the waiver. All questionable items should be verified with the DMAS HELPLINE (800-552-8627 or 800-852-6080). DME information can also be found on the DMAS web site by reviewing the *DME* Provider Manual at www.dmas.virginia.gov.

Equipment and supplies may not be rented. They must be purchased through a Medicaid enrolled DME provider. Each AT item must be recommended and determined appropriate to meet the individual's needs by the following professionals, prior to approval by the DMAS Service Authorization Contractor:

Examples of Assistive Technology Devices (not a comprehensive list)	**Professional Assessment Required**

Computer/Software or Communication Device	Speech Language Pathologist or Occupational Therapist
Organizational Devices	Occupational Therapist, Psychologist, or Psychiatrist
Orthotics, such as braces	Physical Therapist or Physician
Other Specialized Devices/Equipment	Physician, Speech Language Pathologist, Physical Therapist, or Occupational Therapist depending on the device or equipment.
Support Chairs	Physical Therapist or Occupational Therapist
Specially Designed Utensils for Eating	Occupational Therapist or Speech Language Pathologist
Specialized Toilets	Occupational Therapist or Physical Therapist
Weighted Blankets/Vests	Physical Therapist, Occupational Therapist
Writing Orthotics	Occupational Therapist or Speech Language Pathologist

Service Units and Service Limitations

The maximum Medicaid-funded expenditure for AT in the EDCD waiver is $5,000. The Service Authorization must be made during the MFP participation year. The service unit is the total cost of the item and any supplies, or hourly rate for Rehabilitation Engineering. Each item must receive a Service Authorization.

Providers of AT cannot be spouses or parents, of individuals who are minor children, of the individual requesting the services. Providers that supply AT for an individual may not perform assessment/consultation, write specifications, or inspect AT for that individual. Any request for a change in cost (increase or decrease) requires justification, supporting documentation of medical need and a Service Authorization approved by the DMAS Service Authorization contractor.

Provider Documentation Requirements

The documentation requirements are:

- Supporting documentation, which includes the need for the service, the process to obtain this service (contacts with potential vendors or contractors, or both, of service, costs, etc.); and the time frame during which the service is to be provided. This includes separate notations of evaluation, design, labor, supplies, and materials. The supporting documentation must include the reason that a Rehabilitation Engineer or Certified Rehabilitation Specialist is needed, if one is to be involved. A Rehabilitation Engineer or Certified Rehabilitation Specialist may be involved if disability expertise is required that a general contractor will not have;
- Documentation of the recommendation for the item by a qualified professional;
- Documentation of the date services are rendered and the amount of service needed;
- Any other relevant information regarding the device or modification;
- Documentation in the record of notification by the designated individual or individual's representative of satisfactory completion of the service or receipt of the item/goods;
- Instructions regarding any warranty, repairs, complaints, or servicing that may be needed; and
- More than one cost estimate may be required.